Advance Directives and "Do Not Resuscitate" Orders

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Introduction Persons with decisional capacity may formulate a set of Advance Directives as a means of providing instructions regarding future medical decisions in the event that they become incapable of making decisions regarding their own medical care. These tools frequently address various aspects of end-of-life care and may include guidelines for deciding if and when the patient wishes to be resuscitated. This paper will consider the ethical questions associated with several Advance Directives and the "Do Not Resuscitate" order.

The Major Questions

In the second half of the 20th century, technology has advanced to the state that new medical decisions (which were previously never encountered) often have to be made. Some of these decisions have become so routine that deliberation over what constitutes the proper course of action is not necessary. However, other decisions facing patients, their families, and their treatment teams often cannot be made without first considering various complex issues. Examples of such decisions are as follows:

1. Should an intravenous line be placed to provide hydration and treatment? This is generally done now without consideration unless intravenous access is difficult and might require placement of a large line in a large artery such as a "central line" (which may run a higher risk of complications and which usually must be placed by a doctor), or unless the patient has specifically requested that this not be done.

2.
Should a tube be placed to provide mechanical ventilation via the mouth or nose (intubation), or throat (a tracheostomy)? Note that this could include several sub-decisions, with the patient saying yes to one option and no to another.

3. Should a tube other than a simple intravenous line be placed via the nose, the throat, or across the abdominal wall into the stomach or intestines? Again, some of these procedures might be deemed acceptable, while others may not be desired.

4. If a patient’s heart or respiration were to cease, should cardio-pulmonary resuscitation (CPR) be performed? This decision is sometimes sub-divided into the questions of standard CPR, electrical defibrillation (a procedure in which the chest wall is electrically shocked in order to correct an abnormal heart rhythm), and intubation for ventilation.

5. Should other major interventions (such as surgery, chemotherapy, or radiation therapy) be performed if the patient is unable to participate in the decision? If so, under what circumstances and to what desired end? This involves considerations of how major the intervention is and how likely it is to save, prolong, or improve one’s life or to alleviate suffering.

Advance Directives (ADs)

While any instruction pertaining to medical decisions given in advance technically could be considered an Advance Directive, most states have two standard forms for ADs. Many states provide legally for a Health Care Surrogate in the event that neither AD has been completed. [This paper does not address the specifics of each state’s legislation. Please clarify your state’s existing laws on ADs.]

The Living Will (LW) may vary by state, but in general this document allows the patient to decline to be kept alive by medical treatments in the event of a “terminal illness” or "imminent death." In some states, this may apply to situations of persistent vegetative state (PVS) if certified by two licensed physicians.

With the progression of technology, more patients face the possibility of being artificially sustained by ventilators or feeding tubes, prolonging an inevitable dying process. Several highly publicized lawsuits have brought this fear to the public’s attention. While the LW provides physicians and patients’ families with some sense of direction regarding medical decisions, it applies legally only in the three situations listed above and does not designate a specific person (proxy) to assist the treatment team when difficult decisions in the context of other decisions must be made. The LW does not speak to complicated scenarios and therefore is often not very helpful. Furthermore, it gives the patient a false sense of confidence that he or she has responsibly dealt with hypothetical decision-making scenarios, when in fact this document frequently only complicates things.

The Durable Power of Attorney for Health Care (DPAHC) document serves primarily to allow a person to designate a proxy to assist the medical team in making treatment decisions. It
becomes effective when a patient is not capable of assisting in this process. When two doctors, or a doctor and a psychologist, document that a patient lacks decision-making capacity, the proxy becomes the primary decision-maker. (Note: While competency is a legal standard, decision-making capacity is declared at the bedside without resorting to legal interdiction.) The DPAHC allows a person to name a successor to his or her proxy in the event that the proxy is deceased or otherwise unable to assist in making decisions at the time of need. It also allows a person to establish other parameters for limitations of authority. This relatively flexible document provides the patient with the assurance that his or her wishes will be respected, provides the medical team with important legal protection, and may help avoid complicated family disputes. In many ways the DPAHC is superior to the LW, and is generally preferable. In most states it would also be legal to combine the two documents if one so desired.

A Health Care Surrogate is a proxy who is authorized by statute to assist the medical team in making decisions on behalf of a certain patient who does not have an LW or DPAHC. In the event that the patient is unable to communicate and assist in decision-making and a) the patient's death is imminent, or b) the patient suffers from a terminal condition, or c) the patient is permanently or irreversibly unconscious, the health care surrogate can assist in medical decision-making. In most states, the surrogate is determined by a system of prioritization beginning with the patient's guardian (if applicable) and proceeding through the spouse, any adult children, either parent, any adult brother or sister, any adult grandchildren, a close friend, or guardian of the estate.

The Big Questions and the "DNR" Order

If a person has designated a DPAHC and discussed his or her wishes and preferences with this proxy, end-of-life decisions may be relatively straightforward. While as Christians we are not to seek death, nowhere in Scripture is a dying person instructed to do every conceivable thing to prolong an inevitable process. The Roman Catholic Church, along with many conservative Protestant Evangelical scholars and clinical medical ethicists, affirm the right of a dying person to forego treatments that are truly futile, only prolong one's death, or impose significant pain and suffering in exchange for little assistance. The difficult part, at times, is knowing how futile treatments really are, how much benefit might be expected from a given treatment, and how much pain and suffering might result from pursuing further treatment. These questions seldom have clear answers and must be weighed and discussed with the treatment team, one's extended support network, and, hopefully, with one's pastor.

Cardio-Pulmonary Resuscitation (CPR) was invented in the last fifty years and has undergone several modifications since its inception. It is widely taught in safety courses, scout troops, and schools and hospitals around the country. Many people believe that instituting CPR is relatively easy and generally successful when implemented. Both beliefs are untrue. It is not easy to perform proper CPR consistently. This is one reason why frequent re-certification is required of those who take CPR courses. Such people soon forget the exact specifics of CPR technique, and improperly performed CPR is well documented to be ineffective. Furthermore, even if CPR is adequately performed, only 15% of patients who receive CPR in a hospital will leave the hospital alive. This is due to one major consideration: most patients who are sick enough to have a respiratory arrest in the hospital are quite ill, and even if a medical team is able to resuscitate them, such patients seldom recover from their illnesses. Furthermore, CPR is fraught with
complications. Of the patients who do live, many sustain rib fractures or major lung and heart injuries due to CPR. 10% end up in a persistent vegetative state (PVS).

Given these facts, the decision to forego CPR is often reasonable - particularly in cases of incurable illness, irreversible multi-system disease, or other situations involving impending death. The patient or the proxy should make this decision with the physician. It typically requires significant discussion, the details of which should be carefully documented by the physician in the patient's chart prior to writing a "DNR" order. The doctor should write the order clearly, recording it, for example, as: "No CPR, defibrillation, or intubation - please see progress notes." There is no medical or ethical justification for a "slow code," in which the medical staff is expected to go through the motions of resuscitation - even though they know a resuscitation attempt would be doomed to fail - simply to convince the patient's family that "everything possible was done" for their loved one.

For Christians, although death is indeed an enemy, it is a conquered enemy. We know that God is sovereign and that He has appointed a time for us to die. Therefore, we need not anxiously scramble about doing everything in our power to delay God's homeward call. We are to be stewards of all He has given us - including our bodies - but we are not to fear death as might the unbeliever.

References


A Personal Decision, an excellent brochure available through the Illinois State Medical Society, Twenty North Michigan Avenue, Suite Seven Hundred, Chicago, Illinois 60602, 312-782-1654.

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